PHYSICIAN'S HEALTH SUMMARY
FIRST STEPS EARLY INTERVENTION SYSTEM
CHILDREN'S SPECIAL HEALTH CARE SERVICES

State Form 51929 (R / 4-06) / BCD 0119

Division of Disability and Rehabilitative Services

First Steps

Effective May 01, 2006

Your patient is currently in the evaluation process for eligibility for CSHCS and/or early intervention services under Part C of the Individuals with Disabilities Education Act (IDEA). The health summary request is an initial step in this process. Your participation is requested by completing and returning this form. If you have questions, please contact the Intake / Service Coordinator listed below. Your participation in this activity is greatly appreciated.

IDENTIFYING INFORMATION

Name of child	Date of birth (*month, day, year*)
Name of parent / guardian	County
Reason(s) for referral	

CURRENT HEALTH STATUS

Diagnosed medical condition (*please specify*)	ICD codes
Current medications	
Medical precautions	Are immunizations current? ☐ Yes ☐ No
Physical status	
Please note any concerns with vision or hearing	

DIAGNOSED PHYSICAL OR MENTAL CONDITION WITH A HIGH PROBABILITY OF DELAY

Please check all that apply

- ☐ Chromosomal abnormalities or genetic disorder — ICD Code:_____
- ☐ Neurological disorder — ICD Code:_____
- ☐ Congenital Malformation — ICD Code:_____
- ☐ Sensory impairments, including vision or hearing — ICD Code:_____
- ☐ Severe toxic exposure including prenatal exposure — ICD Code:_____
- ☐ Low birth weight ≤ 1500 grams — IDC Code:_____
- ☐ Neurological abnormality in the newborn period — ICD Code:_____

Please indicate specific concerns related to the child's development below

☐ I recommend a developmental assessment be provided to the child to rule out a developmental delay in one or more of the following developmental domains:

- ☐ Cognitive development
- ☐ Physical development (including vision or hearing)
- ☐ Social or emotional development
- ☐ Adaptive development
- ☐ Communication development

Additional comments

Signature of physician	Date (*month, day, year*)
Name of physician (*please print*)	Telephone number ( )

Please return to:	
Telephone number ( )	Fax number ( )

DISTRIBUTION: Original - SPOE; Copy - Primary care physician and family